KANSAS

DIVISION OF HEALTH POLICY AND FINANCE

ROBERT M. DAY, DIRECTOR KATHLEEN SEBELIUS, GOVERNOR

Division of Health Policy and Finance
Annual Report

Presented to
Ways and Means Subcommittee on
Health Policy Authority and
the Division of Health Policy and Finance

Our Mission:

To improve Kansans' access to affordable, quality healthcare by leveraging a more efficient and equitable marketplace through strategic purchasing and by providing meaningful health information.

Our Values:

The Division of Health Policy and Finance is a fiscally responsible, information driven organization that values transparent and effective business practices, and employee development.

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Division of Health Policy and Finance

Statutory History

The Division of Health Policy and Finance (DHPF) was created by House Substitute for SB 272 during the 2005 Legislative Session. DHPF was established on July 1, 2005 within the Department of Administration. At that time, the single state Medicaid agency authority moved from the Department of Social and Rehabilitation Services to DHPF and the State Employees Benefits Section was placed under the same administrative structure.

Simultaneously, the Kansas Health Policy Authority (KHPA) was established as a new agency within the Executive Branch. KHPA is responsible for the development of a statewide health policy agenda including health care and health promotion components and the development of health indicators to include baseline and trend data on health costs. The nine voting members and seven non-voting members were scheduled to be appointed on August 1, 2005. The seven non-voting members are to serve as a resource and support for the voting members. After an initial cycle of staggered terms, members serve four-year terms.

Organization

DHPF is composed of three organizational units. Medical Policy and Medicaid (MP/M), commonly referred to internally as Medicaid, was transferred from SRS. It manages the Title XIX (Medicaid) and Title XXI (SCHIP) programs, as well and other insurance related programs, such as the Working Healthy program. The State Employee Health Plan group, transferred from the Division of Personnel Services, administers the health related benefits programs for state employees. The Finance and Operations group, created in October with staff transferred from the other two units, provides an Agency-wide perspective for budgeting, finance, accounting, legal and other operational matters throughout the division.

DHPF has a total of 180.67 authorized positions in the FY 2007 Governor's Budget Report. This includes 133.87 in the Medical Policy and Medicaid Unit (including Finance and Operations), 39.8 for State Employee Benefits, and 12.0 to support the Kansas Health Policy Authority.

The blending of organizational cultures within the Division is well underway. Successful initiatives in one program have provided learning opportunities in the other program, and processes are being built to ensure Division-wide goals are met in each of our programs.

Responsibilities

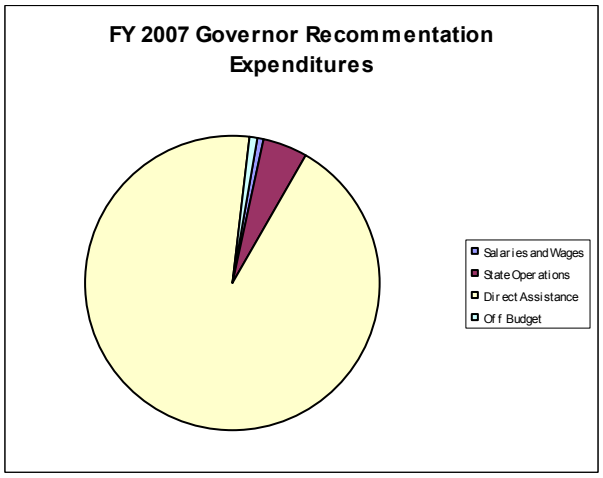
SB 272 tasks DHPF with the responsibility to coordinate health care planning, administration, purchasing and analysis of health data for several state health care programs, including:

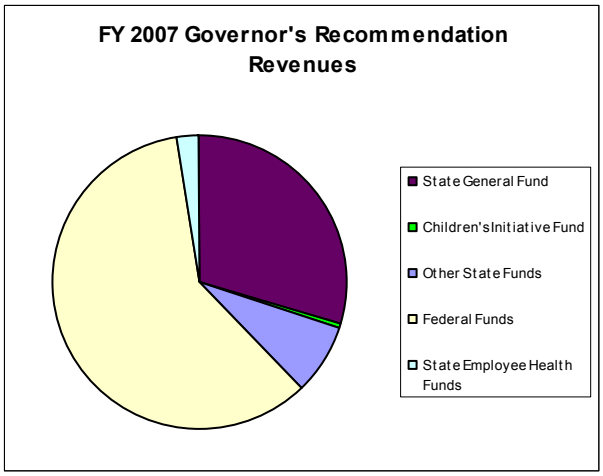
- State-financed health insurance benefits provided through Medicaid or the State Children's Health Insurance Program (SCHIP) for Kansas;
- The MediKan program for those in the process of applying for disability benefits;
- Working Healthy portion of the Ticket to Work Program;
- Medicaid and SCHIP prescription drug benefits, including a system of prior authorization, utilization review, electronic claims, and management of drug formulary; and
- the Medicaid Management Information System (MMIS).

Within the Department of Administration, the Division also administers the state employees health benefits plan and the state employees self-insured worker's compensation program.

DHPF also carries the fiduciary responsibility as the designated single state agency for the Medicaid program, with responsibility to supervise and administer Federal Medicaid funds according to a state plan approved by the Secretary of Health and Human Services.

DHPF Budget Summary





Items included in the Governors Budget

	FY 2006	FY 2007
SCHIP Caseload Additional funds to provide services to 2,500 more children than included in the approved budget and approximate 5,000 more children in FY 2007.	3,549,506	7,776, 503
Reduce Contractual Services Reduces contractual services to align with the approved budget.	-568,151	-5,027,365
Medical Assistance Caseload Reduced the approved budget by $17.8 million, including $5.4 million from the State General Fund primarily due to the separation of Medicaid services between SRS and DHPF. For FY 2007, the recommendation adds $4.3 million from the State General Fund, but makes other financing adjustments to reduce the total funds needed to finance the Consensus Caseload estimate.	-17,887,747	-34,187,747
Community Health Record Additional resources to create an electronic medical record to improve continuity of care.	250,000	
Transfer Operations of Kansas Health Policy Authority Shifts of funding from submitted KHPA budget to DHPF to delay the transition of Medicaid and the State Employees Health Plan until July 1, 2007.	950,173	1,357,868,274
Community Rx Additional resources to expand access to discounted prescription drugs.	200,000	400,000
Business Health Policy Committee Additional funds for small business subsidies for offering health insurance to employees.		1,500,000
Presumptive Eligibility Additional resources provide medical coverage for children presumed to be eligible by trained health care providers.		2,500,000
Healthy Kansas First Five Funds to provide medical coverage through HealthWave for Kansas children through age 5.		3,500,000
Inspector General Provides funding for a new position for independent investigations and reviews for improved integrity of the Medicaid program.		75,000
Employee Cost of Living Increase Funding for the 2.5 percent state employee pay raise.		172,706
Switch Fee Fund for State General Fund $27.0 million in State General Fund dollars are reduced in Medical Assistance and replaced with an equal amount of Social Welfare Fee Fund dollars, based on expected revenues.		0

Highlights and Year in Review

Business Health Policy Committee. The Kansas Business Health Policy Committee (KBHPC) is initiating a pilot program to increase the financial incentives available to small businesses when they decide to offer health insurance to their employees. The program targets working Kansans who are most likely to be uninsured: those with incomes below 200.0 percent of the federal poverty limit who work in small firms with between 2 and 25 employees. The existing small business tax credit will be coupled with additional credits to reduce company contributions to 30 percent of the premium and employee contributions to 10.0 percent of the premium. The program will be offered on a pilot basis in Sedgwick County during the program's first year. Due to the limited target market, bids will be solicited for a single carrier to offer a plan that includes a standard package of benefits emphasizing preventive care, and will be linked to the new CommunityRx Kansas program. The program will be coordinated with HealthWave coverage to enhance the program's impact on uninsured, low income families.

CommunityRx Kansas. CommunityRx Kansas is a statewide prescription assistance program implemented in January 2006 to provide low-income, uninsured Kansans access to affordable prescription medication. CommunityRx Kansas is administered by two local Kansas firms, Right Choice Pharmacy and Prescription Network of Kansas, who together provide a statewide network of approximately 300 participating pharmacies. Since program launch on January 4, 2006, over 200 Kansans have enrolled in CommunityRx Kansas.

Community Health Record. DHPF and FirstGuard Health Plan, the state's only Medicaid HMO, are piloting the use of a limited electronic health record in Sedgwick County. Working with Cerner Corporation, a leading health information technology company based in Kansas City, FirstGuard is developing a network of physicians and hospitals that will access a shared electronic health record that will provide the provider a real time picture of the patient's critical health information including basic demographics, diagnoses, lab results, and prescriptions. In addition, participating providers will be able to use e-prescribing through this web based technology. This record will assure that patients are provided an integrated model of care designed to improve quality and health outcomes.

Healthy Kids. HealthyKIDS is a pilot program that helps eligible state employees with their premium for children's health insurance coverage in the State Employees Health Plan (SEHP). It is aimed at covering children who are ineligible for HealthWave because of federal guidelines which exclude state employee dependents who have access to the state employee plan. State employees with eligible dependent children have 90.0 percent of the premium for their covered children paid for by the state instead of the traditional 45.0 percent. The employee pays the remaining premium. About 1,100 employees were approved for HealthyKIDS, encompassing nearly 2,500 children. Of these children, approximately 550 were previously not enrolled in the state health plan.

Presumptive Disability. On July 1, 2006, DHPF will initiate a Medicaid eligibility option, if approved by CMS, that will take the place of the MediKan program. This option will allow the State to make a preliminary determination of disability that will result in immediate Medicaid benefits for the eligible person. Currently, people who want to apply for Social Security disability programs can receive a limited package of state-funded medical benefits through MediKan for 24 months while the Social Security Administration (SSA) reviews their applications. If, after 24 months, they do not meet SSA eligibility and have exhausted their appeals, they are no longer eligible for MediKan, except through limited hardship criteria.

Under presumptive disability, a determination will be made within 45 days as to whether persons are likely to meet the SSA criteria for disability. If so, they will be determined eligible for the full package of Medicaid services, and the State can immediately claim federal financial participation (FFP) for these services. Simultaneously, they will submit a disability application to the SSA that will follow the usual process. Regardless of whether they are eventually determined disabled by the SSA, the FFP for the medical services they used does not have to be returned by the State.

Everyone in the MediKan program on July 1, 2006 will be screened for presumptive disability in the month of his or her annual review. If they are not presumed disabled though that process and have exhausted all SSA appeals, they will no longer receive medical benefits. There will be no hardship criteria.

Presumptive Eligibility. As part of the Governor's Healthy Kansas initiative, DHPF is developing a presumptive eligibility process for Kansas children under age 19. In partnership with Medicaid providers, presumptive eligibility identifies and assists children who are eligible for medical coverage enroll for services. There are an estimated 40,000 Kansas children who remain without medical insurance. By implementing presumptive eligibility through local hospitals and clinics, many children can begin receiving regular health care. Through this initiative, each health care provider who cares for a presumptively eligible child can count on receiving payment for those services while full eligibility is being determined. Implementing presumptive eligibility will assist the state in connecting children to health insurance programs that they are eligible to receive.

Healthy Kansas First Five. There are more approximately 15,000 uninsured Kansas children from birth through age five. Ten thousand of these children would by income be eligible for current publicly funded health insurance, while another five thousand are above the 200.0 percent the federal poverty level. This initiative would raise the Medicaid eligibility level for pregnant mothers and infants from the current level of 150.0 percent to 185.0 percent of the Federal Poverty Level (FPL) and to increase the eligibility level for children one year to five years of age to 235.0 percent of FPL. Families with children above 235.0 percent of poverty who do not have access to any employer based insurance and who have been without insurance for six months will be allowed to buy into the HealthWave benefit package through a premium based household. The additional cost of these changes is anticipated to be no more than $3.5 million.

Hospital Provider Assessment. In 2004, the Legislature passed Senate Substitute for HB 2912, authorizing the assessment of taxes on community-based acute care hospitals and managed care organizations serving persons on Medicaid. The proceeds from these assessments are to be used to match Medicaid funding to increase reimbursement rates to specific provider groups and, if possible, to expand services and supports. The goal of the program is to more adequately cover the costs of key Medicaid providers thereby improving access to critically needed services. The State Medicaid plan amendment for this program was approved in October 2005. Hospitals received their first retroactive payment increase at the end of December and the new, increased rates were in effect in early January 2006. DHPF is working on raising physician rates to more closely align with Medicare rates. Increases for physicians should be in place before June 2006.

Enhanced Care Management. The Division of Health Policy and Finance has contracted with Central Plains Regional Health Care Foundation to implement the Enhanced Care Management Pilot Program. Central Plains is a not-for-profit arm of the Sedgwick County Medical Society. The five year pilot will be a hybrid of case management and disease management used to coordinate and manage the care of specific high-risk individuals in Sedgwick County. Implementation of the pilot will begin on March 1, 2006. The project is a collaborative effort between the State of Kansas, Central Plains, and the provider community utilizing community-based resources and expertise to improve quality of care and appropriate health care utilization.

Medicare Part D. On January 1, 2006 the Federal government began providing prescription drug coverage to seniors and persons with disabilities who are entitled to Medicare. This new Medicare drug component, called Part D, provides outpatient pharmaceutical coverage through private prescription drug plans. Medicaid beneficiaries who also have Medicare coverage ("Dual Eligibles") will receive drug coverage through Medicare. Representatives from DHPF, the SRS, the KDOA, the Kansas Insurance Department, the KDHE, and the Long Term Care Ombudsman have worked together to inform Medicare beneficiaries about the upcoming change in prescription drug coverage and help dual eligibles find the best plan to meet their needs.

Evidence Based Practice. Evidence-based practice is the conscientious, explicit, and judicious use of current best evidence in making decisions about health care coverage. The DHPF clinical staff continues to utilize the best clinically relevant research in the development of Medicaid services. An example of this practice is the Preferred Drug List (PDL). The PDL Advisory Committee continues to utilize systematic reviews from the Center for Evidence-Based Policy. The State of Kansas has joined a multi-state project called Medicaid Evidence-Based Decisions (MED). The project will provide access to systematic evidence reviews, an information clearinghouse, technology assessments, and research consultation.

Comprehensive Neuroscience (CNS) Project. DHPF is initiating a partnership with the SRS Division of Mental Health to review physician prescribing practices for Kansas Medicaid beneficiaries who receive behavioral health medications. This two year project, called the Kansas Psychiatric Medication Project, is funded by a non-governmental educational grant. The

State will be assisted in implementing the project by Comprehensive Neuroscience, Inc. (CNS). CNS is an independent company with experience in evidence-based practices. The project will compare physician prescribing practice patterns with nationally recognized prescribing guidelines and recommend changes to physicians who deviate from those guidelines. The objective is to identify prescribing patterns of physicians outside the national standard guidelines and educating them through a variety of communication media. All changes on the part of the prescribing physician are voluntary. Targeted education and consultation will allow physicians to self-regulate their own prescribing practices once they become fully aware of best-practice standards.

Medicaid and Medical Policy

What is Medicaid?

Medicaid, as part of Title XIX of the Social Security Act, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to provide adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people. The Federal statute identifies over 25 different eligibility categories for which federal funds are available. These statutory categories can be classified in to five broad coverage groups: Children; Pregnant Women; Adults in Families with Dependent children; individuals with disabilities, and individuals 65 or over.

Medicaid at a Glance
FY 2005

Total Medicaid Expenditures	–	$2.126 billion
Average Monthly Consumers	–	264,494
Unduplicated Individuals	–	364,266
Providers	–	14,367
Average Claims per day	–	57,366

Within broad national guidelines which the Federal government provides, each of the states establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Thus, Medicaid programs, benefits, and policies vary considerably from state to state.

Medicaid in Kansas

In FY 2005, the State of Kansas spent over $2.1 billion purchasing health care for more than 360,000 persons through the Medicaid and HealthWave programs. Medicaid is the third largest purchaser of health care services and the largest purchaser of children's health care services in Kansas. About 64.0 percent of the persons served were low income children and families. Medicaid pays for nearly one-third of the births in Kansas. Persons whose health care is covered by this program are generally:

- Less healthy than the general population;
- Unlikely to have an identified primary care physician;
- Less likely to have had timely immunizations; and
- More likely to seek medical care in expensive hospital emergency rooms.

DHPFs approach to health care for medically under-served Kansans emphasizes preventive services and evidence-based health care practices.

Nearly all health care services purchased by Medical Policy and Medicaid (MP/M) are financed through a combination of state and federal matching dollars either through Title XIX (Medicaid) or Title XXI, the States Children's Health Insurance Program (SCHIP). Under Title XIX the federal government provides approximately 60.0 percent of the cost of Medicaid services with no upper limit on what the federal government will reimburse the State. The State provides the remaining 40.0 percent of the cost of Medicaid services. Under Title XXI the Federal

government provides approximately 72.0 percent of the cost up to a maximum allotment, and the State provides the remaining 28.0 percent and any excess spent above the federal allotment. Health care services are purchased through both traditional fee-for-service and managed care models as described below.

Managing Health Care

Kansas Medicaid offers a choice between Capitated Managed Care and a Primary Care Case Manager (PCCM). In the Fall of FY 2002, the Medicaid Capitated Managed Care Program was combined with the SCHIP program to provide one seamless managed care option for families, called HealthWave. HealthWave serves SCHIP eligible children and Medicaid eligible adults and children in the Temporary Assistance for Families (TAF) and Poverty Level Eligible (PLE) programs. As of January 2006, HealthWave was available in 62 counties for Medicaid beneficiaries and in all 105 counties for SCHIP beneficiaries.

HealthWave coverage is provided through Managed Care Organizations (MCOs). FirstGuard Health Plan Kansas, Inc. is the physical health MCO for Medicaid HealthWave and HealthWave SCHIP. Doral Dental, Inc. serves as the Administrative Service Organization (ASO) for Medicaid HealthWave and the MCO for SCHIP HealthWave for dental services. As of January 1, 2005, Cenpatico is the MCO for SCHIP HealthWave mental health services. A per person, per month rate is paid for each person enrolled in the plan. Persons enrolled in HealthWave select a primary care physician to coordinate their healthcare service needs. Capitated managed care is required by state statute for the SCHIP program, and is continued in the Medicaid HealthWave program because it can create incentives for providing more aggressive preventive health care services such as:

- Child health assessments;
- Immunization and well child care;
- Assertive prenatal care; and
- Care management for persons with chronic diseases like asthma.

DHPF plans to continue to increase the number of persons served through a capitated managed care model. Using value-based purchasing strategies, the program intends to increase access to quality healthcare and encourage the development of a managed system of care that promotes long term health and wellness through the use of MCOs. As of January 2006, a total of 113,183 persons, 76,043 in Title XIX and 37,140 in Title XXI, were enrolled in HealthWave.

Primary Care Case Managers (PCCMs) are primary care providers who manage health care by providing services or referring persons to medical specialists. HealthConnect Kansas is Kansas' PCCM program. The HealthConnect providers receive a case management fee of $2 per member per month and services are reimbursed on a fee-for-service basis. As of January 2006, there were 87,343 persons served by HealthConnect.

Fee-for-Service Title XIX Medicaid. DHPF provides persons not on HealthWave with health care coverage on a fee-for-service basis. Many of the people in this portion of the Medicaid program are frail elderly, or have disabilities, and by federal rule, cannot be required to enroll in a managed care program.

Title XXI/The State Children's Health Insurance Program (SCHIP). Through SCHIP, Kansas combines state and federal funds to purchase health care services for uninsured children from low income families. SCHIP provides free or low cost health insurance coverage to children who:

- Are under the age of nineteen;
- Have family incomes too high to qualify for Medicaid;
- Have family incomes under 200.0 percent of the federal poverty level; and
- Are not covered by state employee health insurance or other private health insurance.

As of January 2006, there were 37,189 children enrolled in SCHIP. In addition, the SCHIP outreach process has resulted in an additional 73,288 children being found eligible for Medicaid. Therefore, since the implementation of SCHIP in January 1999, an estimated 140,617 Kansas children who were uninsured received physical, mental, and dental health coverage.

MediKan. MediKan provides a reduced health care benefit for individuals in the process of applying for disability through the Social Security Administration. When the person receives a final disability determination, they become eligible for Medicaid and the state can recover the federal share of providing services. Until that point, MediKan services are funded entirely from the State General Fund. The MediKan benefit is not as comprehensive as Medicaid, but includes some inpatient and outpatient hospital care, prescription drugs, mental health services, limited durable medical equipment, and home health care. A recent study of the services provided to MediKan beneficiaries showed that 61.8 percent of MediKan costs are for prescription medications, Community Mental Health Center services, and hospitalizations. DHPF is working to develop a presumptive disability procedure to expedite the review of disability determinations and quickly identify individuals that would otherwise be eligible for Medicaid. During FY 2005, 4,499 persons received health services through MediKan.

Medicaid Management and Oversight Responsibilities

In addition to funding health care services, DHPF is the single State agency responsible for the integrity of all Medicaid and SCHIP funded programs in Kansas. Not only does the Medicaid program serve as a major source of federal financing for other programs in Kansas, MP/M assists other State agencies in complying with Medicaid rules and regulations, including the Kansas Department on Aging, the Department of Social and Rehabilitation Services, the Juvenile Justice Authority, the Kansas Department of Health and Environment, and the State Department of Education. This responsibility requires constant communication with consumers, physicians, dentists, pharmacists, managed care and long-term care providers, and myriad of others who play a very important role in the success of this program.

Who is Eligible for Medicaid?

Medicaid serves as the nation's primary source of health insurance coverage for the poor. During the past decade, federal and state eligibility policy changes to promote Medicaid coverage of low-income pregnant women and children, persons with disabilities, and the elderly have resulted in greater coverage of these groups within the low-income population. In exchange for federal financial participation, states agree to cover certain groups of individuals (referred to as "mandatory groups") and offer a minimum set of services (referred to as "mandatory benefits"). States also can receive federal matching payments to cover additional optional groups of individuals and provide additional optional services. The decision by a state to cover an optional population or to provide optional benefits has important implications not just for Medicaid beneficiaries, but also for the state and health care providers that otherwise might be paying for, or providing health services to low-income residents.

Federal matching payments through Medicaid often allows states to partially refinance the cost of services that states have traditionally provided at its expense, or to pay for services that otherwise might be written off by providers as bad debt or charity care. The terms on which federal Medicaid matching funds are available to states include five broad requirements related to eligibility: categorical, income, resources, immigration status and residency. In order to be eligible for Medicaid, an individual must meet all of these applicable requirements.
The availability of federal matching funds for particular categories of individuals, however, does not necessarily mean that a state will cover these individuals, since the state must still contribute its own matching funds toward the cost of coverage.

A more detailed list of eligibility categories and criteria is included in Appendix 1.

Medical Assistance Expenditures:

Title XIX Medicaid	FY 2005 Actuals	FY 2006 Revised	FY 2007 Gov Recommendation
Expenditures	$ 1,222,183,106	$ 1,218,206,167	$ 1,205,596,247
Persons Served Each Month	292,625	269,827	279,155

Title XXI HealthWave	FY 2005 Actuals	FY 2006 Revised	FY 2007 Gov Recommendation
Expenditures	$ 55,395,517	$ 61,525,860	$ 69,302,363
Persons Served Each Month	33,888	36,535	41,486

MediKan	FY 2005 Actuals	FY 2006 Revised	FY 2007 Gov Recommendation
Expenditures	$ 29,808,639	$ 21,793,833	$ 23,718,253
Persons Served Each Month	4,499	4,443	4,516

Medical Assistance Revenue Sources:

	FY 2005 Actuals	FY 2006 Revised	FY 2007 Gov Recommendation
State General Fund	$ 424,777,450	$ 407,862,576	$ 397,125,803
Children's Initative Fund	$ 8,850,000	$ 5,000,000	$ 5,000,000
Social Welfare Fund	$ 35,675,932	$ 40,789,636	$ 67,789,636
Health Care Access Improvement Fund		$ 57,348,002	$ 41,572,853
Title XIX	$ 793,874,465	$ 743,429,758	$ 734,402,883
Title XXI	$ 40,258,594	$ 44,541,646	$ 50,171,446
Other Federal Funds	$ 3,950,821	$ 2,554,242	$ 2,554,242

Payment Accuracy and Claims Monitoring

DHPF purchases health care services on behalf of eligible customers using a combination of state and federal funds. These purchases are typically initiated by customers who engage providers for medically necessary services, resulting in a claim for reimbursement from the provider to the state fiscal agent, Electronic Data Systems, or one of the state's managed care contractors. As with the majority of Kansans who purchase health care services under the terms of a private insurance contract, Medicaid purchases must follow a set of guidelines. Many of the rules governing provider claims for Medicaid reimbursement are mandated by the federal government, others are designed to meet specific program objectives established by the state, and the remainder are dictated by the realities of the marketplace.

DHPF employs a variety of strategies to ensure accuracy in its health care payments. Each year the Medicaid and SCHIP programs reimburse thousands of providers for millions of claims totaling over $2 billion. These purchases reflect the level of access we are able to sustain for the 300,000 customers who are enrolled in these programs each year. Our objectives in managing these payments are to reimburse legitimate claims quickly, to resolve inadvertent errors fairly, and to detect and address illegitimate claims appropriately. These payments are managed by a comprehensive claims monitoring system, primarily through a continuously-updated cycle of pre-payment screens, post-payment reviews, and post-review actions. Payment screens and reviews are administered primarily through the electronic Medicaid Management Information System (MMIS), which evaluates, or "adjudicates," claims for Medicaid reimbursement.

Pre-payment monitoring serves to stop irregular claims from being paid that would likely end up being erroneous payments. Pre-payment screens include those designed to ensure that payments are made only for approved Medicaid services, that these payments are made only to legitimate Medicaid providers, and that payments are made only on behalf of customers enrolled in the program at the time of the service was provided. Pre-payment monitoring is a form of cost avoidance in that preventing an erroneous payment saves both the cost of the payment and the efforts associated with detecting and recovering the erroneous payment from a provider. During FY 2005, Medicaid screened out $313.0 million in claims payments through the pre-payment monitoring process.

Post-payment monitoring consists of revisiting claims that have already been paid out by the system. These reviews examine payments at the individual and provider level and are designed to detect patterns of claims that could reflect erroneous, fraudulent, or abusive behavior. Remediation for erroneous claims includes provider and customer education, restrictions on future claims by a provider or customer, and/or recoupment of funds. Cases of suspected fraud are forwarded to the Medicaid fraud control unit in the Attorney General's office for potential prosecution. In FY 2005, Medicaid identified $87.0 million in overpayment to providers through post-payment reviews.

State Employees Benefits Section

The Legislature created the Health Care Commission in 1984 and gave it the authority to design and implement a health care benefits program. An Office of Health Benefits Administration was established that provided for the development of the State Health Care Benefits Program and the contracting associated with it. The Division of Accounts and Reports provided accounting services. The Division of Personnel Services was responsible for the Section 125 Cafeteria Plan.

State Employee Benefits at a Glance	
State Employees	**35,022**
Non-State Employees	**6,052**
--School Districts	
--Counties, Cities and Townships	
--Other employer groups	
Retirees and COBRA	**8,998**
Total Individuals Covered	**88,000**

In 1995, administration of the Plan as well as the Office of Health Benefits Administration was consolidated into the Division of Personnel Services, providing a seamless organization of the development and administration of the Plan.

Statute provides for an Employee Advisory Committee which was implemented in 1995. It consists of 21 members; 18 active employees and 3 retirees serving three year rolling terms.

In 1999 the Health Care Commission approved allowing other governmental employer groups into the plan. Underwriting guidelines were developed to assure that state employees would not be adversely affected by this decision. Because it was subsequently determined that there were different costs between the non-state employer groups and state employees, the non-state employer groups do pay a different composite rate and employee premiums.

As mentioned earlier, House Substitute for SB 272 created the Division of Health Policy and Finance and the Kansas Health Policy Authority which includes state employee health plan and workers compensation.

Health Plan Enrollment

Total plan enrollment in the State Employee Health Plan is just over 50,000 contracts and about 88,000 covered lives. In plan year 2006, 92.0 percent of employees are enrolled. Of those, 56.0 percent carry single coverage and 44.0 percent provide coverage for their dependents.

There are 97 non-state group employers participating in the plan, consisting mostly of schools and municipalities. The non-state group employers include 35 school districts; 42 cities, counties or townships; and 20 other local units such as water districts, libraries and extensions. The number of participants in the non-state groups range from 1 to 524. Only 5 groups have more than 200 and 13 have between 100 and 200 members.

In addition to the active employees, we provide coverage for nearly 9,000 retirees and former employees living in all states and some abroad.

Health Plan Design

The Health Care Plan has four components: medical, prescription drug, dental and vision.

Medical. All participants have a choice of preferred provider organizations (PPOs) and, where available, a Health Maintenance Organization (HMO) option as well. For plan year 2006, 60.0 percent of active participants chose an HMO. Retirees have the same choices of provider networks. Retirees who are Medicare eligible also can enroll in a self funded Medicare Supplement Plan and, beginning with 2006, a Medicare Advantage Plan offered by Coventry. We spent $85.1 million in 2005 on medical claims for the self funded plans administered by Blue Cross Blue Shield and Harrington, and about $126.0 million in premiums for the fully insured plans.

Prescription Drugs. Prescription Drugs are carved out of the health plan and administered separately by a Pharmacy Benefits Manager (PBM). We carved out our prescription drug plan effective January 1, 1996. We implemented a tiered coinsurance program that included a separate out of pocket maximum for special medications and discounts for lifestyle drugs. Our generic dispensing rate is now over 52.0 percent. Drug expenditures in through the PBM have been about half of the national average since we implemented this design. Annual claims cost for 2005 was $62.0 million. Caremark is the State's PBM.

Dental. The dental component is provided by the employer for employees at no cost, and it is optional for dependents. In 2005, $18.1 million was paid in claims. Delta Dental of Kansas provides administrative services for the dental benefit.

Vision. The Employee Advisory Committee (EAC) requested that a voluntary vision plan be offered. It provides two benefit levels and is completed funded by participants. There are 22,300 participants. Superior Vision is the vendor.

State Employee Benefit Organization

DHPF administers the plan including eligibility, membership, payments, and continuation provisions for retirees and former employees. The Division of Accounts & Reports within the Department of Administration provides the payroll accounting function. External billing for retirees, former employees, and the non-state group is provided by CONEXIS.

Contract managers are responsible for plan design, contract development, contract management and helping participants understand benefits, resolve claims, or services issues customer service. Data analysis staff uses the Medstat Advantage Suite product, a web based claims analysis and decision support system, to review claims experience and monitor trends in all of the health plan benefit areas.

Recent Developments

In 2004, the State Employees Health Plan moved to a "buy-up" funding mechanism. Essentially the state contribution is based on the lowest cost option available; and the employee has the ability to "buy-up" to another plan. This has been effective in containing costs.

For 2006, the employer contribution for dependent coverage was increased from 35.0 percent to 45.0 percent of the premium cost. This is the first increase since the late 1990's and resulted in additional enrollments of dependents in the health plan.

HealthyKIDS was introduced for 2006. It provides for an employer contribution of 90.0 percent towards the premium for low income families who are eligible for HealthWave, but can not enroll due to federal law. In 2006, almost 1,100 families with over 2,400 children get this extra help.

Medicare Part D gave us some opportunities to look at new options for retirees. For 2006, Medicare eligible Direct Bill participants may elect out of drug coverage in the state's Medicare Supplemental Plan and enroll in a commercial Part D Plan with considerable savings. Thirty percent of enrolled participants decided to do this. Additionally over 100 retirees enrolled in the new Coventry Medicare Advantage. Also for 2006 we arranged for participants with dependents to split their enrollment if one was Medicare eligible and the other was not, so each individual could take advantage of the plans specific for their situations. In all 170 of the 450 members in this situation took advantage of this opportunity.

State Employees Self Insurance Fund (Workers Compensation)

The workers compensation program for state employees is called the State Self Insurance Fund (SSIF). The Fund was implemented through legislation in 1972 and consolidated into the Division of Personnel Services in 1988. It is a self insured, self administered program with 15 staff members to administer the program.

The SSIF is funded by agency rates based on experience rating. The rates are developed by an actuarial service using three years of claims experience, payroll and caps on expenses. Rates are currently approved by the Department of Administration and published by the Division of Budget.

The SSIF processes and manages claims for injuries that arise out of and in the course of work. There is unlimited medical compensation to treat the injury. Additionally compensation is made for loss of time, permanent impairment or death. Medical payments are based on a fee schedule developed by the Workers Compensation Division of the Kansas Department of Labor. A third-party medical review service is utilized to review claims for medical appropriateness and pricing.

On average, 300 accident reports are received monthly. In FY 2005 the SSIF spent over $16.0 million on compensation, with about 55.0 percent for medical services and 45.0 percent for loss time compensation.

In addition, there are two health and safety specialists on staff who work with all state agencies to assess workplace safety and to propose solutions, including ergonomics, physical plant safety, air quality.

Appendix 1

Medicaid Eligibility Groups and Delivery System

Eligibility Categories

- All physician and hospital visits
  - PLE (primarily children and pregnant women)
  - TAF (primarily children, mothers and some families)
- Eligibility by reason of income and disability – physical or mental disability determined by social security insurance (SSI)
- Eligibility by reason of income and age
  - Over 65

Optional Populations/Benefits

- HCBS
- Breast and Cervical Cancer
- AIDS Drug recipients
- Working Healthy

Title XIX and Title XXI Eligibility

- Family income must be less than the indicated federal poverty level listed below:
- Title XIX
  - To age six – 133 percent of the federal poverty level
  - Age six to nineteen – 100 percent of the federal poverty level
- HealthWave Title XXI
  - To age one – 150 percent of the federal poverty level
  - Age one to nineteen – 200 percent of the federal poverty level

The Medicaid Title XIX Fee for Service

- All physician and hospital visits
- Dental for children
- Mental health services
- Pharmacy
- Minimal co-pay (no more than $3)

Title XIX Medicaid – PCCM Managed Care

- Health Connect
- Available in all counties
- 87,000 children and adults
- Physicians
- Certified Nurse Practitioners
- Certified Nurse Midwives
- Indian Health Centers
- Federally Qualified Health Centers
- Rural Health Clinics

HealthWave XIX

- Capitated managed care plan for physical health
- 76,000 children and adults

HealthWave XXI / State Children's Health Insurance Program

- Children under 19
- Family income under 200 percent FPL
- No other family health insurance
- 37,000 children enrolled
- Capitated managed care for physical, mental & dental health

Capitated Managed Care Delivery Systems

- FirstGuard HealthCare of Kansas (HealthWave)
  - Title XIX
  - Title XXI
- Doral Dental
  - Title XXI
- Consortium
  - Title XXI

Appendix 2

Medicaid Spending by Eligibility Group

FY 2005 Major Eligibility Categories of the Kansas Medical Assistance Program
Division of Health Policy & Finance

Temporary Assistance to Families (TAF)

Low income families with children who meet the financial limits of TAF are eligible for medical coverage. Not all families are receiving a TAF cash benefit. Income limit is based on family size, county of residence and who the family is living with. For most three person families their limit is $403/month. Nearly half of all medical expenditures involve childbirth/newborn care.

FY 05 Average monthly caseload	65,183
Number of different persons served	109,154
FY 05 Average monthly medical cost	$186
FY 05 Total Cost (Major expenditures below)	$145,140,300
Managed Care	51,872,671
Inpatient Hospital	32,158,918
Physician Servies	20,387,665
Pharmacy	15,395,023
LEA	7,246,459
Dental Services	6,888,567
Outpatient Hospital	6,699,568
Lab & Radiology	985,295

Medically Needy - TAF Families

Pregnant Women and non-disabled children under 19 who do not qualify for regular medical because of income may still be eligible for coverage. All income above $480/month (family of three) is used to determine spenddown. The spenddown is much like an insurance deductible and is usually for a 6 month period. Medical expenses equal to the amount of the spenddown must be incurred. Once the spendown is met, covered medical services may be paid until the end of the spenddown period.

FY 05 Average monthly caseload	697
Number of different persons served	1,760
FY 05 Average monthly medical cost	$332
FY 05 Total Cost (Major expenditures below)	$2,777,035
Inpatient Hospital	1,318,884
Pharmacy	714,934
Physician Servies	433,319
Outpatient Hospital	126,401
LEA	54,275
Dental Services	51,470
Lab & Radiology	18,777
Transportation	17,795

Low Income Children

Children under the age of 19 may be eligible for coverage based on the income of the family.

	Family of 3 Monthly Income
Infants under 1 yr old under 150% of poverty guidelines	$2,012
Child 1 through 5 under 133% of poverty guidelines	$1,784
Child 6 through 18 under 100% of poverty guidelines	$1,341

	Infants	Children
FY 05 Average monthly caseload	14,424	68,795
Number of different persons served	29,213	112,634
FY 05 Average monthly medical cost	$437	$99
FY 05 Total Cost (Major expend. below)	$75,686,299	$81,373,142
Managed Care	26,201,785	18,858,727
Inpatient Hospital	34,785,223	7,929,576
Physician Servies	9,947,886	12,416,650
Pharmacy	2,053,986	11,144,953
Dental Services	26,207	12,119,143
LEA	192,570	11,941,245
Outpatient Hospital	825,246	3,985,696
Supplies	470,958	466,359

Low Income Pregnant Women

Coverage for pregnant women through the second post partum month is available if income is under 150% of poverty.

	Family of 3 Monthly Income
Pregnant Women under 150% of poverty guidelines	$2,012
FY 05 Average monthly caseload	6,758
Number of different persons served	17,670
FY 05 Average monthly medical cost	$764
FY 05 Total Cost (Major expenditures below)	$61,971,637
Managed Care	25,084,124
Inpatient Hospital	19,270,188
Physician Servies	12,550,675
Outpatient Hospital	1,997,542
Pharmacy	1,423,394
Lab & Radiology	811,387
Dental Services	276,665
Transportation	135,569

Foster Care

Youth in the custody of SRS or JJA who are living in an eligible out of home placement are eligible for coverage. Youth leaving foster care on or after their 18th birthday are covered until they reach age 21.

	SRS	JJA
FY 05 Average monthly caseload	5,372	1,252
Number of different persons served	8,214	2,405
FY 05 Average monthly medical cost	$343	$306
FY 05 Total Cost (Major expend. below)	$22,114,244	$4,603,551
Pharmacy	8,557,878	2,163,595
Inpatient Hospital	4,441,094	534,647
Physician Servies	3,147,816	644,958
LEA	2,518,580	301,509
Dental Services	1,478,144	508,984
Outpatient Hospital	805,061	209,711
Supplies	415,123	7,102
Transportation	318,184	34,376

TAF Extended Medical

Families who lose medical coverage under the Low Income Families with Children group because of employment can receive and additional 12 months of coverage. A small number also receive continued coverage when they receive child support income.

FY 05 Average monthly caseload	9,076
Number of different persons served	22,419
FY 05 Average monthly medical cost	$152
FY 05 Total Cost (Major expenditures below)	$16,510,233
Managed Care	6,899,951
Physician Servies	2,272,199
Inpatient Hospital	2,129,738
Pharmacy	2,069,129
LEA	1,004,488
Dental Services	873,295
Outpatient Hospital	772,898
Lab & Radiology	112,790

Adoption Support	
Medical assistance is provided to special needs children who have been adopted and receive Adoption Subsidy.	
FY 05 Average monthly caseload	4,868
Number of different persons served	5,479
FY 05 Average monthly medical cost	$183
FY 05 Total Cost (Major expenditures below)	$10,714,187
Pharmacy	4,359,252
LEA	2,903,618
Inpatient Hospital	1,060,260
Physician Servies	928,281
Dental Services	522,353
Supplies	418,111
Outpatient Hospital	260,783
Transportation	93,023

SCHIP	
Children under the age of 19 whose family income is above the Medicaid limit but is below a monthly income for a family of three of $2,612.	
FY 05 Average monthly caseload	33,767
Number of different persons served	59,138
FY 05 Average monthly medical cost	137
FY 05 Total Cost (Major expenditures below)	55,502,696
Managed Care	55,015,934
Pharmacy	275,693
Dental Services	211,069

Data is only for Health Policy & Finance so expenditure data is not comparable to last year's report. The monthly caseload average and different persons served are comparable to the prior year reports. Expenditures for SRS, Aging, and Juvenile Justice Authority are not included.
All non client specific expenditures, such as Disproportionate share are not included on the report
Pregnant women expenditures are significantly higher than prior year's expenditures due to a catch up of lump sum delivery payments made for managed care beneficiaries.

FY 2005 Major Eligibility Categories of the Kansas Medical Assistance Program
Division of Health Policy & Finance

Supplemental Security Income - Aged	
Persons receiving SSI payments through Social Security are eligible for medical assistance. SSI payments are available to persons who are 65 and over and meet the means test (eg income & resources). A large percent are on Medicare.	
FY 05 Average monthly caseload	6,420
Number of different persons served	7,273
FY 05 Average monthly medical cost	$514
FY 05 Total Cost (Major expenditures below)	$39,592,841
Pharmacy	18,555,790
Medicare Buy-In	7,901,296
Inpatient Hospital	6,010,264
Home Health Services	2,196,765
Physician Servies	2,041,144
Hospice	924,069
Outpatient Hospital	655,434
Supplies	586,239

Supplemental Security Income - Disabled	
Persons receiving SSI payments through Social Security are eligible for medical assistance. SSI payments are available to persons who meet the disability criteria and the means test (eg income & resources). Children under age 18 are also included in this category.	
FY 05 Average monthly caseload	31,711
Number of different persons served	37,213
FY 05 Average monthly medical cost	$693
FY 05 Total Cost (Major expenditures below)	$263,565,327
Pharmacy	104,023,850
Inpatient Hospital	76,770,756
Physician Servies	27,391,817
LEA	11,901,495
Outpatient Hospital	11,277,317
Medicare Buy-In	8,372,294
Supplies	7,347,212
Home Health Services	6,751,516

Medically Needy - Aged (SSI)	
All persons have a resource test. Almost all beneficiaries are covered by Medicare. Includes 1) regular Medically Needy group with spenddown; 2) persons living in an NF or other institution who are required to pay a portion of their income toward the cost of care (includes spousal impoverishment cases); 3) persons not receiving SSI who get HCBS services in the community.	
FY 05 Average monthly caseload	17,414
Number of different persons served	23,218
FY 05 Average monthly medical cost	$545
FY 05 Total Cost (Major expenditures below)	$113,959,060
Pharmacy	68,531,551
Medicare Buy-In	15,257,767
Hospice	15,011,020
Inpatient Hospital	5,672,515
Supplies	2,637,827
Home Health Services	2,472,897
Physician Servies	2,397,163
Outpatient Hospital	753,294

Medically Needy - Disabled (SSI)	
All persons have a resource test and meet Social Security disability criteria. Many beneficiaries are covered by Medicare. Includes 1) regular Medically Needy group with spenddown; 2) persons living in an NF/other institution who are required to pay a portion of their income toward the cost of care, including state hospital residents; 3) persons not receiving SSI, who get HCBS services in the community, including children; 4) employed persons with a disability under the Working Healthy Program.	
FY 05 Average monthly caseload	15,454
Number of different persons served	20,964
FY 05 Average monthly medical cost	$688
FY 05 Total Cost (Major expenditures below)	$127,634,825
Pharmacy	59,602,539
Inpatient Hospital	33,074,992
Medicare Buy-In	9,594,811
Physician Servies	8,520,005
LEA	3,426,824
Home Health Services	3,293,947
Outpatient Hospital	3,223,598
Supplies	2,182,852

Qualified Medicare Beneficiary (QMB)		Other Populations	
Persons below 100% of the FPL ($798/month) have their Medicare premiums, coinsurance & deductibles paid (QMB program). Persons below 135% of the FPL ($1077/month) have their Medicare Part B premiums paid (LMB program). Medicare Part A premiums are paid for a small number of employed persons (QWD program). A resource test exists: $4000 for a single & $6000 for a couple.		Medicaid covers several other small groups, including refugees, children in institutions, women with breast or cervical cancer, people with tuberculosis and certain non-citizens who are elible for emergency services only. This also includes the non-Medicaid AIDS drug assistance program (ADAP).	
FY 05 Average monthly caseload	5,932	FY 05 Average monthly caseload	1,003
Number of different persons served	8,148	**Number of different persons served**	1,981
FY 05 Average monthly medical cost	$90	FY 05 Average monthly medical cost	$1,570
FY 05 Total Cost (Major expenditures below)	$6,393,433	FY 05 Total Cost (Major expenditures below)	$18,900,731
Medicare Buy-In	5,444,173	Inpatient Hospital	9,190,596
Physician Servies	405,648	Pharmacy	6,701,151
Outpatient Hospital	198,948	Physician Servies	2,416,373
Inpatient Hospital	167,964	Outpatient Hospital	440,785
Supplies	96,659	Hospice	41,771
Home Health Services	45,911	Transportation	24,056
Lab & Radiology	12,610	LEA	20,341
Hearing Services	10,283	Lab & Radiology	19,615

Title XIX For Gen Asst Disabled		Grand Total	
This includes individuals who are severely disabled and who do not yet have a decision regarding permanent federal disability status. These are MediKan clients. The MediKan program provides a more limited package of services.			
FY 05 Average monthly caseload	4,499	FY 05 Average monthly caseload	292,625
Number of different persons served	8,608	**Number of different persons served**	383,692
FY 05 Average monthly medical cost	$441	FY 05 Average monthly medical cost	$305
FY 05 Total Cost (Major expenditures below)	$23,790,466	FY 05 Total Cost (Major expenditures below)	$1,070,230,008
Pharmacy	8,665,074	Pharmacy	314,241,031
Physician Servies	5,780,873	Inpatient Hospital	239,143,517
Inpatient Hospital	4,627,902	Managed Care	183,933,192
Outpatient Hospital	2,850,903	Physician Servies	111,682,470
Home Health Services	648,250	Medicare Buy-In	46,536,036
Lab & Radiology	414,737	LEA	41,538,693
Supplies	354,037	Outpatient Hospital	35,083,185
Transportation	173,114	Dental Services	24,816,375

Data is only for Health Policy & Finance so expenditure data is not comparable to last year's report. The monthly caseload average and different persons served are comparable to the prior year reports. Expenditures for SRS, Aging, and Juvenile Justice Authority are not included.
All non client specific expenditures, such as Disproportionate share are not included on the report
Pregnant women expenditures are significantly higher than prior year's expenditures due to a catch up of lump sum delivery payments made for managed care beneficiaries.

Appendix 3

Poverty Guidelines 2005

Medical Assistance Program	Percent of 2005 Poverty Level	Annual Income Guidelines For 1-5 Member Households				
		HH1	HH2	HH3	HH4	HH5
*MediKan	25%	2,352	3,216	N/A	N/A	N/A
*Caretaker Medical	30%	2892	3912	4,836	5,652	6,384
*Medically Needy	60%	5,700	5,700	5,760	5,820	6,000
*SSI Related (SSA Limit Applies)	76%	7,236	10,848	N/A	N/A	N/A
*HCBS Waivers	89%	8,592	N/A	N/A	N/A	N/A
Children Ages 6-18; Qualified Medicare Beneficiaries	100%	9,570	12,830	16,090	19,350	22,610
	110%	10,527	14,113	17,699	21,285	24,871
	120%	11,484	15,396	19,308	23,220	27,132
Children Ages 1-5	133%	12,728	17,063	21,400	25,736	30,072
Partial Dual Eligibles	135%	12,920	17,321	21,722	26,123	30,524
	140%	13,398	17,962	22,526	27,090	31,654
Pregnant Women & Infants; Medicare Part D Subsidy	150%	14,355	19,245	24,135	29,025	33,915
	160%	15,312	20,528	25,744	30,960	36,176
	170%	16,,269	21,811	27,353	32,895	38,437
	180%	17,226	23,094	28,962	34,830	40,698
TransMed	185%	17,705	23,736	29,767	35,798	41,829
	190%	18,183	24,377	30,571	36,765	42,959
Title XXI-SCHIP	200%	19,140	25,660	32,180	38,700	45,200
	210%	20,097	26,943	33,789	40,635	47,481
	235%	22,490	30,151	37,812	45,473	53,134
	250%	23,925	32,075	40,225	48,375	56,525
Working Healthy	300%	28,710	38,490	48,270	N/A	N/A

* Income limits for these programs are based on income standards and are not tied to the federal poverty level. For comparison purposes the standards have been converted to approximate poverty levels.

Appendix 4

Testimony from Special Committee on Medicaid Reform